TRANSACTIONS

OF THE

NEW YORK SURGICAL SOCIETY.

Stated Meeting, November 23, 1904.

The President, HOWARD LILIENTHAL, M.D., in the Chair.

MULTIPLE SPONTANEOUS FRACTURES.

DR. CHARLES L. GIBSON presented a woman, forty-nine years old, who gave a fairly well-defined specific history. Aside from this, her past history had apparently no bearing upon her present condition. Seven years ago, a spontaneous fracture of the right ulna had occurred. At the site of the fracture, a lump, presumably a gumma, had previously been observed. This fracture had never united, and the patient stated that no attempt had ever been made to induce it to unite. Two years ago a spontaneous fracture of the proximal phalanx of the right middle toe occurred. Seven months ago she fell out of bed and sustained a fracture and dislocation of the left shoulder. About three months ago she noticed a swelling over the right clavicle, and a spontaneous fracture subsequently occurred at the site of the tumor. All these fractures were perfectly painless, and a considerable amount of function of the affected parts was retained. Dr. Gibson thought there was little doubt that the underlying clause of these spontaneous fractures was syphilis. In most of the cases of the kind on record, the bones united. The patient had been put on specific treatment, but the speaker said he did not expect much benefit therefrom.

DR. ROYAL WHITMAN called attention to the fact that the fractured clavicle had apparently united. The fracture of the shoulder, he said, could hardly be called spontaneous, as it had been produced by a fall out of bed. It was rather interesting that the fractures, aside from the one involving the phalanx of one toe, were confined to the upper extremities. He recalled a number of cases of spontaneous fractures in children whose bones were congenitally weak, in one instance as many as twenty or thirty fractures having occurred. The patient was a boy who could at one time hardly turn in bed without sustaining a fracture of some bone. He was kept in plaster-of-Paris for years, and finally recovered, although, as is the rule in these cases, a dwarf in stature.

OSTEOPLASTIC AMPUTATION OF THE LEG.

Dr. Howard Lilienthal presented a man, thirty-eight years old, who, when he first came under observation, had a sloughing gangrene of one big toe, with threatened gangrene of several of the adjoining toes, the cause evidently being an arteriosclerosis. The affected toe was amputated, but the disease progressed; and it finally became necessary to amputate the leg, which was done in April, 1904.

As the cause of the gangrene was arteriosclerosis, with presumable hardening of the bones, the speaker said he regarded a simple amputation, done as rapidly as possible, as most advisable; but he was finally persuaded by Dr. A. V. Moschcowitz, who had had considerable experience with certain osteoplastic amputations, to try the osteoplastic method. In a much more promising case than this, in which Dr. Lilienthal had tried that method a year before, the patient became somewhat septic, necessitating removal of the bone-section. Subsequently, the patient became insane, and was transferred to Bellevue Hospital. In spite of the unsatisfactory result in that case, and in spite of the fact that an osteoplastic operation was apparently contraindicated in the case just shown, the operation was undertaken with Dr. Moschcowitz's assistance, and, contrary to the speaker's expectations, the result was excellent. There was a slight infection following the operation, due to the fact that the wound had to be left open, and one or two small superficial necrotic pieces of the fibula came away, but the main section of bone remained in place. The cicatrix of the stump was in a location where, under ordinary conditions, it would be painful; but under the circumstances it was not painful at all, and the man was able to bear considerable weight on it without inconvenience. The bones were eburnated, and so brittle that fissure of the tibia occurred on fracturing of the osteoplastic flap. Division with the Gigli saw was very difficult. The stump left, however, was infinitely better than could be obtained by any of the ordinary methods, even with a periosteal cuff. Dr. Lilienthal said he would certainly resort to the method again in similar cases, and in amputations of the femur also.

DR. WHITMAN said it was rather peculiar that only one leg was affected. The speaker said that this condition of arteriosclerosis was not uncommon in comparatively young people, and especially among the Jewish race. These patients complained of pain in the legs and calves, often more pronounced at night, and of "weak feet," and an examination usually showed that the toes were of a deep violet color. Both lower extremities were generally equally affected.

DR. LILIENTHAL, in reply to a question, said that the section of bone protecting the stump had been left attached by a periosteal hinge, so that it could be turned on itself. The fragment of bone should be handled as little as possible; otherwise, the periosteum was apt to become stripped off entirely.

Dr. Lilienthal said that while these cases of gangrene resulting from arteriosclerosis were rare, he had seen and operated on quite a number of them. As Dr. Whitman had said, they appeared to be more common among the Jewish race, and every year a certain number of them came under observation at Mount Sinai Hospital. The condition was usually bilateral, and in one case that had recently come under his observation, a young man of twenty-eight years, a Lisfranc amputation was necessary on one foot and a leg amputation on the other side. In the case under discussion, the patient complained somewhat of the opposite foot, but the condition had not progressed to the point of gangrene. As to the etiology of the condition, no positive statements could be made. The cases were variously described as Raynaud's disease, arteriosclerotic gangrene, and erythromelalgia. In its terminal stages, after the onset of the gangrene, it was a disease of the blood-vessels, usually of the arteries, sometimes of the veins also, and apparently depending on some nerve lesion. It usually occurred in early middle life, and was seldom seen in old people. In his experience, the oldest patient was fifty-six years. It was unusual to get a syphilitic history in these cases, and he did not think that syphilis was an important etiological factor in the disease.

A DEVICE FOR THE TREATMENT OF FRACTURE OF THE FEMUR IN CHILDREN.

Dr. Theodore Dunham presented this device.

Dr. Charles N. Dowd referred to the difficulty of treating this form of fracture in children under one year of age. He referred to the device which the late Dr. Van Arsdale had suggested a number of years ago. This consisted of a triangular splint which was fixed between the flexed thigh and the body, to one side of which the thigh was bound. He had found difficulty in maintaining good apposition with this apparatus, and would certainly try Dr. Dunham's method if the opportunity presented. In older children he had found the suspension treatment very satisfactory.

Dr. Whitman said that in his experience with fractures of the femur in young children in the out-door service, union of the bone was usually very slow. This was probably due to the fact that the ambulatory treatment of these cases by the ordinary methods was unsatisfactory and difficult to carry out, because, as a rule, fractures in children united very readily. Even the method described by Dr. Dunham might be difficult to apply in this class because of the soiling and displacement of the plaster dressings.

Dr. Dunham, in closing, said it was a fact that nearly all of his cases were treated in the hospital wards. In answer to the statement that the treatment of fractures of the femur in dispensary practice was troublesome and not very satisfactory, and to the question whether any of his cases were treated in dispensary, he cited the case of a nursing infant fifteen days old which he had treated entirely in the out-door department by the method which he had devised, and, although the splint became more or less soiled, it did not become displaced. The child suffered very little discomfort, developed no irritation of the skin, and made a perfect recovery. Dr. Dunham said he had treated six cases in children by this method, and in all of them the bone united very promptly and with a singularly small amount of callus. In one case where the fracture occurred in the hospital ward and was promptly treated, it was impossible to feel any callus at all. One advantage of the method was that the limbs could be so easily inspected, and the course of the treatment, the deformity, etc., so carefully followed.

Stated Meeting, December 14, 1904.

The President, HOWARD LILIENTHAL, M.D., in the Chair.

RESECTION OF THE STOMACH FOR CARCINOMA.

DR. WILLY MEYER presented a man, forty-nine years old, who, when he first came under observation in May, 1904, was in a very deplorable condition. At that time he had been suffering for a number of months from vomiting, and had become greatly reduced in weight and strength. There was a distinctly palpable tumor to the right of the median line in the epigastric region, and analysis of the stomach contents pointed to a tight stricture at the pylorus.

On May 6 the abdomen was opened, revealing a large mass at and beyond the pylorus, principally involving the upper horizontal part of the duodenum. It was very firm, and there were secondary deposits in the lesser and greater omentum in the shape of many minute snow-white appearing glands. The question arose, whether to do a gastro-enterostomy or a resection. On account of the comparative youth of the patient, and the possibility of entirely extirpating the secondary deposits, it was decided to do a radical operation. Between two large clamps the stomach was divided, and almost the entire lesser curvature removed. The proximal end of the stomach was closed in the usual manner, and its cut surface inverted. In the course of closing the divided end of the duodenum by means of a purse-string suture, one of the mesenteric arteries was accidentally wounded, and caused considerable hæmorrhage. Prolonged compression failing to stop the latter, the vessel was finally singled out by compressing it between the fingers and surrounded with a catgut ligature, which was gently tied. As an additional safeguard, the head of the pancreas was placed on top of the inverted and sutured end of the duodenum. A posterior gastro-enterostomy was then done with Murphy's button, and an omental flap stitched over the duodenum and the head of the pancreas.

The patient made an uneventful recovery from the operation, and had since gained more than thirty pounds, resuming his business. The button was passed on the fifteenth day. The mass in the stomach proved to be a carcinoma.

USE OF GUTTA-PERCHA IN OPERATIONS FOR CORRECTING NASAL BONY DEFECTS.

Dr. Robert H. M. Dawbarn said he had first employed gutta-percha in operations for correcting nasal bony defects about ten years ago, and upon several previous occasions had presented patients who were thus treated to the Society. The method was essentially as follows: A strip of dentist's gutta-percha was softened over an alcohol lamp, and then, before the patient was put under an anæsthetic, it was moulded over the nose until it exactly fitted into the particular deformity presented, and corrected it. It was then dipped into ice-water and allowed to harden. The patient was then placed under an anæsthetic (general); next gauze is packed in each nostril, well back, to prevent blood running into the pharynx. Then a knife was inserted into the nostril, and the skin and periosteum as far as possible stripped from the nasal bone on the side on which deformity existed; the incision being carried up as far as the nasal junction with forehead and as close as possible to the infra-orbital vessels without wounding them. Often it is necessary to enter both nostrils to do this work—when the trouble is central. Next sterile tape soaked in diluted adrenalin chloride is packed into the cavity prepared for the new bridge, until in about ten minutes all bleeding ceases and the tape is removed. Into this incision the moulded piece of gutta-percha is then slipped until it rests upon and corrects the nasal deformity. It is held in place by a small bandage on either side of the nose, and a strip of surgeon's plaster, and this completes the operation.

Dr. Dawbarn said he had now done this operation fifteen times, in one or two instances as long as ten years ago, and in every case, with a single exception, the correction of the deformity had been satisfactory and permanent, and the gutta-percha had remained unchanged and devoid of irritation. In one instance where he had endeavored to improve upon the work of the Lord, and create a Roman nose where none was intended, the tissues were stretched too tightly over the gutta-percha, resulting in inflammation of the skin, which finally broke down, revealing the gutta-percha underneath. In four of the remaining cases there was suppuration, but this soon subsided, and the final result of the operation was in no way impaired thereby. The nostril-cuts are not sewn, and pus, if any, gravitates readily away from the new bridge.

Dr. Dawbarn said he was first induced to try this substance for the correction of nasal deformities by the suggestion of a dentist, Dr. Kimball, of New York City, who told him that he had employed it for the purpose of crowding down a non-malignant epulis, and had found it unirritating. The speaker said he considered this method preferable to that of injecting paraffin, which could not be relied upon to be permanent, and which in some instances had resulted in instant unilateral blindness, and in others had gradually changed its shape, with a poor final result. Also, the paraffin injection method inevitably causes some tension where injected, and this violates the first rule of plastic work, which is to have all structures in abundantly loose contact.

Dr. Ellsworth Eliot, Jr., said that while the method of correcting bony defects described by Dr. Dawbarn was an excellent one and a great advance in nasal surgery, he recently had a case in which he thought it would not have proved entirely efficacious. In the case referred to, instead of the usual "sunken nose" deformity, there was a decided increase in the transverse diameter of the organ. This was corrected by a subcutaneous osteotomy. An incision was made, and the two bones were forcibly crowded inward and at the same time forward.

Dr. Lilienthal asked Dr. Dawbarn whether he had tried this gutta-percha material for the purpose of filling bony defects following osteomyelitis? In those cases various paraffin-iodoform mixtures were now being used, but if gutta-percha was as unirritating as Dr. Dawbarn had described, it should be an ideal material for such purposes.

Dr. Dawbarn, in closing, said that two of his cases of nasal deformity were of the type referred to by Dr. Eliot, and the operation comprised two different steps. First, the bones were divided by narrow chisel or slender-jawed bone-forceps, and then crowded over towards the median line. After an interval of some months, to allow the inflammatory symptoms to subside, the gutta-percha plate or bridge was moulded to fit the hollow in the skin, and then was inserted, in the manner described, upon these remnants of bone as a bed.

In reply to Dr. Lilienthal, Dr. Dawbarn said that about two years ago, at the City Hospital, he operated on a case of necrosis of the tibia. The sequestrum was removed, and the remaining bony defect, which was of considerable size, was filled with gutta-percha. Unfortunately, doubtless on account of some defect in the technique, suppuration occurred. Under proper conditions the speaker thought that this material might possibly be entirely satisfactory for the purpose of filling these bony defects, and certainly deserves a further trial.

CHRONIC LARYNGEAL STENOSIS.

DR. JOHN ROGERS presented a man, twenty-five years old, who had a severe attack of typhoid fever in 1900, followed by acute œdema of the larynx, which necessitated a tracheotomy. The acute condition gradually subsided, but left a permanent stenosis with ankylosis of one arytenoid cartilage, and the breathing became so difficult that a tracheal cannula was constantly worn. Under cocaine, the trachea was dilated with urethral sounds until a No. 45 F. was admitted. A modified O'Dwyer intubation tube was then inserted, which the patient was still wearing. The modification, which was devised by Dr. Rogers, consisted essentially of an attachment projecting at right angles from the centre of the tube through the tracheal fistula. This attachment was removable, and after the insertion of the tube was screwed into the tube through the fistula, thus keeping the fistula patent and the tube in place.

HÆMORRHOIDS.

DR. LILIENTHAL presented a young man who had recently been operated on for hæmorrhoids by the clamp and cautery method. After the masses, which were fairly large, had been clamped and cauterized, the skin was elevated at the mucocutaneous junction with the mouse-tooth forceps, and a cut radiating from the anal aperture was made with the scissors: then another and another similar cut was made, until there were five or six radiating incisions. Dr. Lilienthal said he had adopted this modification of the ordinary clamp and cautery operation some years ago, because he had found that by making these incisions there was not only no pain following the operation, but it also prevented the occurrence of dangerous œdema of the parts, with the possibility of subsequent infection.

Upon completing the operation, a dry dressing was applied, and a light tampon tube inserted. After six hours this was replaced by a glycerin dressing.

DR. ROGERS said that about a year or two ago he saw a case in the practice of a colleague where the patient nearly bled to death after a clamp and cautery operation for hæmorrhoids. He recalled another case, seen more recently, where the patient, who gave a history of blood in the stools, was found to have hæmorrhoids, which were removed by the clamp and cautery method. Some hours after the operation, which was done out of town, the patient had a fatal hæmorrhage, and at the autopsy it was found that he had had an ulcerative colitis, and that the bleeding had come from an ulcer in the region of the sigmoid flexure.

DR. IRVING S. HAYNES said he had always held the view that the pain complained of after the clamp and cautery operation was due to the fact that a bit of skin had been included in the clamp, and cauterized. In order to prevent this, it had long been his custom to divide the skin before putting on the clamp, letting the incision extend a short distance into the rectum. Since adopting this method, he had never heard the patient complain of pain after the operation.

DR. GEORGE E. BREWER said that while he favored the clamp and cautery method, his experience with the unmodified operation had been similar to that mentioned by Dr. Lilienthal in regard to subsequent pain. Another disadvantage was the possible occurrence of a large cherry-like swelling, resulting from œdema of the mucous membrane, which the patient was apt to regard as a hæmorrhoid that had been overlooked. In order to prevent this, Dr. Brewer said he had adopted the use of a rather thick spool-shaped plug made of a drainage-tube, surrounded by gauze, and shaped so that the gauze came in contact with all the cut surfaces. This prevented hæmorrhage and infection, and by pressing the plug well upward every vestige of mucous membrane was forced inside, and the possibility of subsequent œdema avoided.

DR. DAWBARN said he was first induced to use a rather stiff rubber drainage-tube by a disagreeable experience he had some years ago. In that instance a soft tube, wrapped with gauze, was inserted into the rectum after an operation for hæmorrhoids. On the third day reversed peristalsis set in, and the tube, with the gauze, was drawn upward into the bowel. The tube was removed without any trouble, but, in order to extract the gauze, it became necessary to anæsthetize the patient and bring it down with much difficulty, from the sigmoid by massage plus a uterine forceps. Cathartics and enemas had been tried, but proved ineffectual. At present, Dr. Dawbarn always in such operations fastens gauze and tube for wind-passage together with a big safety-pin; and this, linked with a second pin, is secured to the dressing outside the bowel

Dr. Lilienthal said the severe pain after the usual clamp and cautery operation was probably due to the œdema in a region that was peculiarly sensitive. Dr. Haynes, in dividing the skin surrounding the tumor before putting on the clamp, practically accomplished the same purpose as Dr. Lilienthal did in making incisions radiating from the anal opening.

TRANSTHORACIC RESECTION OF THE LOWER END OF THE ŒSOPHAGUS IN A DOG, UNDER NEGATIVE AIR-PRESSURE IN SAUERBRUCH'S BOX. A PERSONAL EXPERIENCE.

Dr. Willy Meyer read a paper with the above title.

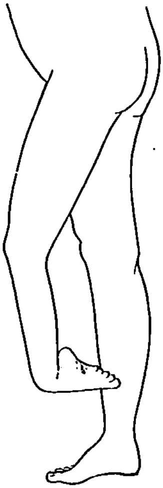

FIG. 1.—Walking on dorsum of foot. Toes distinctly backward.

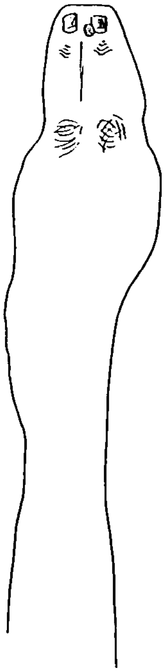

FIG. 3.—Left hand.

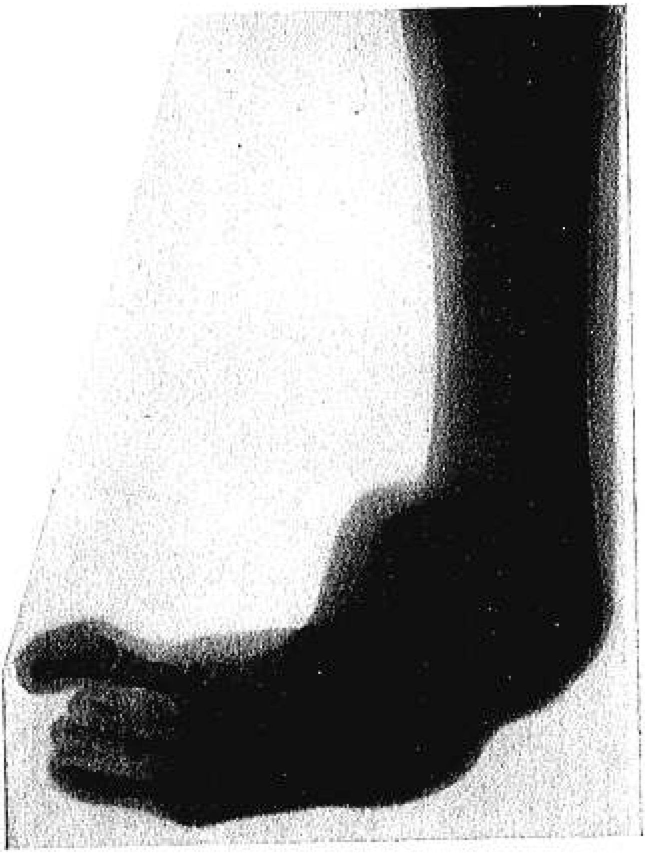

FIG. 2.—Congenital deficiencies of bones of foot.

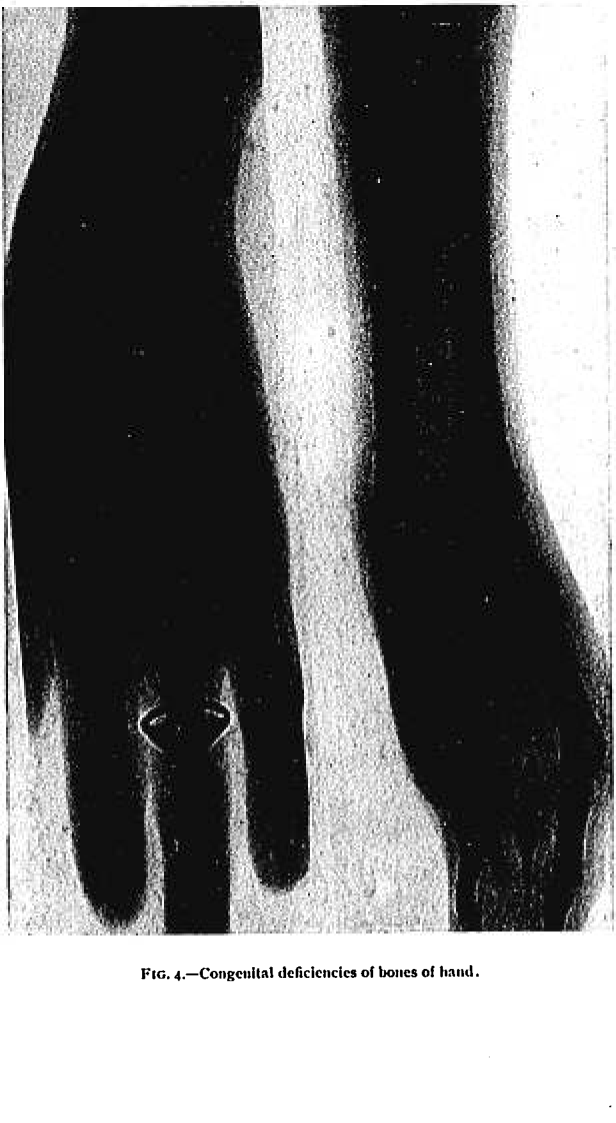

FIG. 4.—Congenital deficiencies of bones of hand.